ESSEX DERMATOLOGY

MA INITIALS: ______

## Health History

****Please complete the front and back of this form****

**Name:** ________________________________ **DOB:** ______________ **Date:** ________________

**Reason for today's visit:** ____________________________________________________________

**Medical History (please circle all that apply)**

| | | | |
|---|---|---|---|
| Anxiety | COPD | Heart Failure | Lymphoma |
| Arthritis | Coronary Artery Disease | Hepatitis | Prostate Cancer |
| Asthma | Depression | High Blood Pressure | Radiation Treatment |
| Atrial fibrillation | Diabetes | HIV/AIDS | Seizures |
| Bone Marrow transplant | End Stage Renal Disease | High Cholesterol | Stroke |
| BPH | GERD | Thyroid Problems (Hyper or Hypo) | Pacemaker |
| Breast Cancer | Hay fever / Allergies | Leukemia | **NONE** |
| Colon Cancer | Hearing Loss | Lung Cancer | |

Other: ____________________________________________________

**List any surgeries:** ____________________________________________________________

____________________________________________________________________________

**Skin Disease History (please circle all that apply)**

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| Actinic Kertatoses | Eczema | Precancerous Moles |
| Basal Cell Skin Cancer | Flaking or itchy scalp | Psoriasis |
| Blistering Sunburns | Melanoma | Squamous Cell Skin Cancer |
| | | **NONE** |

Other: ____________________________________________________

**Melanoma Family History:** Mother Father Sister Brother Daughter Son Other ______________________

**Do you wear sunscreen?** Yes No If yes, what SPF? ____________

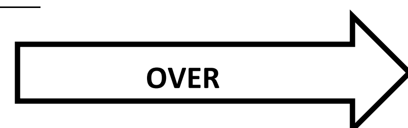
**Do you tan in a tanning salon?** Yes No

**Medications (please list all medications, vitamins, herbal and dietary supplements, etc)**

| Name | Dose (if known) | How often? (Daily, twice daily, etc) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies:** ________________ ____________________ ____________________

________________ ____________________ ____________________



**Cigarette / Tobacco use (circle):**

Never a smoker

Former smoker

Current smoker (some days)

Current smoker (every day)

**Have you received a flu shot in any of the following months? (circle)**

September, October, November or December of 2020

January, February or March of 2021

**If you did NOT receive a flu shot, please circle the reason below:**

Allergic

Declined

Vaccine not available (shortage)

**Pharmacy Name:** ________________________________________________

**Street:** __________________________________________________________

**Town:** __________________________________________________________

**Primary Care Provider:** ___________________________________________

**Date of last visit with Primary Care Provider:**________________________

## ***65 years of age and older ONLY***

**Have you ever received a pneumonia vaccine?** Yes No

**Do you have a power of attorney for your healthcare?**

Yes No

**If yes:** Name:______________________________________

Phone #:____________________________________